POLICY HANDBOOK

WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Minimum Compensation
Code No: 10.1.1
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Reference:

Workers' Compensation Act, Section 35, 35A, 35B

Policy:

Section 35 set out the minimum wage to be paid, with effective dates, as listed below.

Where a worker is a part time or casual worker and earns less than the minimum wage, their actual wages will be paid.

General:

Effective Date	Minimum Wage	Minimum Weekly Wage	Minimum Compensation
January 1,1974	$1.65	$ 66.00	$ 49.50
July 1, 1974	1.80	72.00	54.00
October 1, 1974	2.00	80.00	60.00
January 1, 1975	2.20	88.00	66.00
March 1, 1975	2.25	90.00	67.50
January 1, 1976	2.50	100.00	75.00
January 1, 1977	2.75	110.00	82.50
October 1, 1980	3.00	120.00	90.00
October 1, 1981	3.30	132.00	99.00
October 1, 1982	3.75	150.00	112.50
January 1, 1985	4.00	160.00	120.00

The above calculations are based on the average 40 hour week.

The minimum compensation payable under Section 35 (1) shall be the amounts shown in the last column above on the respective dates.

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Policy Statement
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Subject:
Workers Travel Expenses
Code No: 10.2.1

Policy:

1. When workers are called to Halifax or other places by the Board for hearings, examination, treatment, etc., the workers' travel expenses will be paid as follows:
   a. bus or train — actual fare will be paid, receipts required
   b. private vehicle — mileage will be paid at current rate
   c. meals, lodging, parking, etc. — will be paid at current rates; and
   d. travel from/to home to bus/train depot — will be paid mileage or taxi cost — receipts required

2. Air transportation can be provided for workers called to Halifax from the Cape Breton or Yarmouth areas if the worker wishes.

   When the Board arranges travel for a worker and issues a travel warrant, a small cash allowance ($5.00) to cover incidental expenses will be provided.

3. When a claim is disallowed (new or additional period) a worker may have additional information submitted. Expenses incurred in coming to the Board offices, medical appointments, hearing not arranged by this Board, will not be accepted. If however, the claim is allowed as a result of additional information submitted, expenses for medical appointments during the period accepted will be allowed.

4. It is the workers' responsibility to keep any appointments arranged. Failure to do so may affect further compensation payments.

5. A worker waiting for transportation home may wait in the "holding room" at Point Pleasant Lodge.

6. All expenses must be submitted to the Medical Aid Department with appropriate receipts for payment.

7. Escorts: Medical Aid decides, with advice from the Medical Department. Each claim must be reviewed on individual merit.

Policy:

Travel in Local Areas

1. Cost of travel in local areas for medical treatment, Board arranged appointments, will be paid as follows:
   a. actual bus, train fares:
   b. private vehicle mileage at current rate:
   c. taxi fares will be paid if pre-authorized, or circumstances justify and proper receipts are provided.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Workers use of Taxi to Rehab Centre
Code No: 10.3.1

Policy:
When workers are in Halifax for physiotherapy or other rehabilitation treatment and accommodated at Point Pleasant Lodge:

— use of taxis is permitted only when previously authorized by the Medical Aid Department, or in inclement weather

— workers will be advised of this policy when reporting here to begin treatment.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Travel Expenses for Rehabilitation or Treatment
Code No: 10.4.1

Policy:

Workers in Halifax for physiotherapy or other rehabilitation treatment may go home for weekends after they have completed their treatment on Friday and are required to return on Monday.

Expenses will be paid on an actual cost basis up to a maximum of $90.00.

When a worker is in Halifax for an extended period for treatment, air fare or actual travel expense shall be paid every fourth weekend.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Accommodation & Expenses in Halifax
Code No: 10.5.1
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Policy:

1. Claimants who are called to Halifax for treatment, examination, evaluation, hearings, etc., are generally accommodated at Point Pleasant Lodge. If alternate hotel accommodations are approved, a similar allowance may be paid.

2. Meal allowance will be paid at the per diem rate of $23.00 including gratuities, i.e.; breakfast — $5.00, lunch — $6.00, dinner — $12.00.

3. Claimants who have been called to Halifax, as noted above, and have to remain a week or more, may elect private accommodations and meals at the house of a relative or friend, will be allowed *up to* $90.00 per week for room and board. If this situation applied to one overnight stay only, an allowance of $15.00 per night and $17.00 per day for meals is made.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Hospital Admissions: (Semi) Private
Code No: 10.6.1

Policy:

When a worker is to be admitted to hospital for treatment, investigation, etc., and is placed on a waiting list, semi-private or private accommodation will be authorized if this will result in earlier admission.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Clothing Allowance: Amputees etc.
Code No: 10.7.1
Page 1 of 1

Reference:
Workers' Compensation Act, Section 60(4)

Policy:
Under Section 60(4) a clothing allowance may be authorized when the information in the claim file indicates there is additional wear to the worker's clothes as a result of a prosthetic device, full-length brace or is confined to a wheelchair as a result of a compensable injury. The amount paid is determined by section 60(4) of the Act. If a worker requires different sized clothing as a result of wearing a prosthetic device, etc., the clothing allowance can be provided on a one-time basis. For subsequent years, clothing allowance may be considered according to the usual guidelines.

General:
When a clothing allowance is indicated, the worker is to be advised of his possible entitlement and given an application by the Medical Aid Division.

The application for clothing allowance will be reviewed by the Medical Aid Division who will authorize payment or indicate disallowance by an entry on a Form 51.

Clothing allowance will be paid on July 1st of each year. Awards made during the year will be prorated on a monthly basis.

A worker is entitled to clothing allowance when he/she wears or is:

1. Prosthetic device; amputation must be at or above the wrist or at or above the ankle.

2. Orthotic device, including back brace or support:
   a. A back brace is defined as a device which has a rigid frame for supporting the back;
   b. A back support is defined as being a canvas belt orcorset with steel stays for the purpose of supporting the back. This would not include Camp and Duprey corsets.

3. Confined to a wheelchair;

4. The worker will be paid the clothing allowance according to the evidence of excessive wear presented to the Medical Aid Division. The amount of wear will be determined by a Medical Officer by an examination, usually conducted at the time of his PPD examination, or a special examination as required.

The effective date for payment shall be the date the device was first worn/used or October 1982, whichever is the more recent.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Attendant Allowance
Code No: 10.8.1
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Reference:
Workers' Compensation Act, Section 60(3)

Policy:
This allowance is usually paid on Permanent Total Disability claims but in some instances may be payable on certain Permanent Partial Disability claims and for specific periods of time, on some Temporary Total Disability claims.

General:
The allowance is approved and paid by the Medical Aid Department after direct consultation with the Director of Medical Services. In certain claims special medical reports may be required.

In general, the allowance is based upon the severity of the compensable medical impairment of the claimant. Basically, the allowance is to assist claimants regarding mobility, self care and any 'in house' treatment that is required for the compensable condition.

The allowance may be paid directly to the injured worker, spouse or other attendant.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Loss of Wages/ Hearings Examinations Treatments etc.
Code No: 10.9.1

Policy:
Workers can be paid for loss of wages when they are called or instructed by the Workers' Compensation Board to report for a hearing, examination, treatment, etc..

General:
Compensation will be at the regular rate as per established rules.

Payment cannot be made to workers who lose wages as a result of attendance at hearings, etc. when the worker appears on his own volition.

Reference:
Workers' Compensation Act 1981, Medical Aid

Policy:
The Board will accept chiropractic treatment under the following guidelines.

General:
Fees and Accounts
Payments will be made in accordance with the schedules used by M.S.I. and the Board. This relates to office and home visits with treatment and completion of Form 8 and 10 as requested. X-rays — $25.00. At least two views must be taken.

The Board Will Not Pay For
— More than one treatment in any one day
— For daily treatment unless clearly indicated;
— For house calls unless clearly indicated;
— For treatment of conditions not considered within the scope of chiropractic skills.

Approval of accounts by the Board will be based solely and finally on the information given in the written reports furnished to the Board.

Submission of Accounts
All accounts must be submitted within twelve months from the dates of treatment.

Reports
When an injured worker reports for treatment, the attending chiropractor will complete and submit Form 8. These forms should be filled out with care, and should be as concise as possible. When the Board's Medical Officers do not see the patients, they must get their understanding from reports. The Form 8 should be signed personally by the chiropractor and be submitted within three days of first attendance.

From time to time the Board will request a Progress Report (Form 10) on the injured workers. This will be sent directly to the worker who will take it to the chiropractor for completion and return to the Board immediately.

Delay in submitting Form 8 and Form 10 will only delay payments of compensation to the injured worker.

Accounts are to be submitted to the Board on Form 92 indicating dates and place of treatment(s), condition of patient and treatment given.

All reports are considered confidential.

Period of Treatment
Generally chiropractic treatment will not be paid for beyond four weeks (interpreted as 20 treatments), but in certain circumstances an additional two weeks (interpreted as 10 additional treatments) may be granted after review of the claim. This additional treatment must have prior authorization of the Board's Medical Department.

Leaving the Province
No worker receiving treatment can leave the Province without prior authorization from the Board.

Examination by the Board
The Board may at any time request the worker to report to its own Medical Officer for examination or by any specialist of its choosing.

Extra Billing
Under no circumstances shall a worker be charged any amount to supplement fees paid or to be paid by the Board for services to which the worker is entitled by virtue of the Workers' Compensation Act.

Consultations
The Board recognizes that an injured worker may consult any chiropractor without prior authorization from the Board, regardless of whether the worker has been receiving treatment from a medical doctor.

Consultations with Medical Specialists
This must be arranged either through the family doctor or a Board physician.

Disputes
Any doubt, dispute or misunderstanding regarding the foregoing, will be settled by agreement between the Director of Medical Services of the Board and the Executive Committee of the Nova Scotia Chiropractic Association.

Section 9A of the Workers' Compensation Act was repealed and the following section assented to on June 24, 1981:

> "Any coal miner who has worked at the face of a mine or in similar conditions for twenty years or more and who suffers from a loss of lung function will be compensated according to his disability."

The Board has defined that the expressions:

"face of a mine" to mean any coal miner who is/was employed by a coal company and works/worked underground for a period of twenty years or more;

"similar conditions" applies to coal miners who are/were employed by a coal company and works/worked at the wash plant, at or near the bankhead or on the shipping/coal piers.

The Board further directs:

(a) that new applicants who qualify under Section 9A will need a completed Form 6, 7, and 8s to open a claim;

(b) that once a claim has been opened an appointment for a lung function test will be arranged and interpreted;

(c) that an applicant who has been examined by lung function testing whether allowed or disallowed shall be recalled as soon as possible after three years have elapsed, from the date of the applicant's last test for automatic assumption, unless medical evidence justifies an earlier re-xamination; however the Board strongly recommends that each applicant undergo a chest x-ray for his own personal health. These x-rays may be requested by the applicants family doctor and reported on a Form 8s;

(d) that applicants who have previously made a claim that was allowed or disallowed will not be required to fill out new forms but will be obligated to keep the W.C.B. informed of any changes affecting their file;

(e) that new applicants who do not qualify under Section 9A will be processed under our normal procedures;

(f) that an applicant who for various reasons is unable to obtain his work record, a sworn affidavit before a commissioner of the supreme court of the province is the only accepted document.

Procedure
Internal procedures for processing a 9A claim will be followed as outlined below:

1. Application received by claims department.
2. Application checked for necessary forms.
3. Previous file obtained, if applicable.
4. Processed by units.
5. Form 51 placed on file.

6. For those claimants already receiving silicosis/pneumonoconiosis pensions and who will be receiving an additional pension under 9A, no change is to be made on the jacket firm number. The file jacket is to be clearly stamped with "Automatic Assumption" and contain either the firm number 885 self-insurers, or firm number 886 regular employer.

   For new claims accepted use firm number 885 for self-insurers and firm number 886 for regular employers claims.

   For previously disallowed claims that will now be covered under Section 9A, the file jacket is to be stamped "Automatic Assumption " with the new firm number applied, 885 or 886.

7. Change notice completed. All claims under 9A to be recorded indicating name, claim number, employer, new firm number, original firm number, etc.

8. Responsibility of the medical secretary to sort files in preparation for appointments with doctors and/or hospitals.

9. Necessary appointments are completed and noted on form 51.

10. Record is entered in the computer system.

11. File is transferred back to claims department.

12. Expenses are paid if necessary.

13. File remains in units.

14. Lung function tests reports are received by the medical secretary and the decision entered into the computer program along with the re-examination date for follow-up purposes.

15. Medical report sent to claims department and placed on applicant's file.

16. Form 51 completed by Claims Adjudicator for appropriate action.

17. Files where pensions are awarded are referred to the pension unit for processing.

18. All medical aid and other payments made on a 9A claim are to be charged to Firm Number 885 or 886.

19. The increase in benefits as a result of automatic assumption will be recorded separately with a cheque issued for the increased portion under the new firm number.

General Claims
The provisions covering the general type of pneumonoconiosis claims are set out in Section 74 to 82 inclusive of the Statute.

The following guidelines as to procedures, handling and adjudication of such claims are established, subject to the fact that each claim, finally, has to be considered on its own merits or on any characteristics or elements peculiar to a particular claim or claimant;

(a) For each new pneumonoconiosis claim opened, the W.C.B. Director of Medical Services reviews the claim file along with the local chest films that are sent in. If the Director of Medical Services feels there is sufficient radiological evidence to make a diagnosis of pneumonoconiosis, the claimant is put on the list to be called in for full examination by a chest specialist.
If, however, the Director of Medical Services does not feel there is sufficient evidence to make a diagnosis of pneumonoconiosis, the x—rays along with the work history of the claimant are referred to two independent specialists for readings. If either one of these specialists feels there is sufficient evidence to warrant a diagnosis of pneumonoconiosis, then the claimant is brought in for full examination, which includes a complete clinical assessment along with pulmonary function tests and further chest x-ray examination. If both specialists agree that there is not sufficient evidence to warrant a diagnosis of pneumonoconiosis then the claim is officially disallowed at that time.

(b) On receipt of the two specialists' reports concerning either x-ray assessment or examination assessment, the Director of Medical Services puts forth the opinions and recommendations of these reports to the claims adjudicators who make the final decision on the claim. In some cases, additional medical information, etc. must be obtained before a final recommendation can be made.

Calculations for Automatic Assumption Costs
A miner who qualifies for Automatic Assumption and has worked for more than one employer, the mine where he worked the longest, that is, the total number of years employed under the conditions as set forth above, will be charged the amount for all funds expended, medical aid, pensions, etc.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Fee Schedule Assessment: Automatic Assumption Claims
Code No: 10.12.1

The Board approves the following policy in regards to fees paid to *chest specialists* for assessment of Automatic Assumption claims:

Chest specialists who assess claims for Automatic Assumption, that is, interpreting the lung function tests and giving a permanent partial disability rating are to be paid a fee of 30 units under the M.S.I. schedule.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Voluntary Autopsy Reports Deceased Pneumoconiosis Pensioners
Code No:10.13.1

The following procedure is followed in connection with voluntary autopsy reports from pathologists on deceased miners who are receiving pneumonoconiosis disability pensions.

1. The pathologists in the Cape Breton area be informed that in all cases in which autopsy is carried out on one of the claimants who has been diagnosed as having Coal Miners' Pneumonicosis and where it is felt this condition has directly caused or played a significant part in the claimant's death, that one whole lung be sent as soon as possible to the Pathology Institute in Halifax. Appropriate identification will be sent with each lung.

2. The W.C.B. accepts responsibility for the cost of containers used to transport the lungs together with the transportation costs.

3. The Pathology Institute will review the lung in gross and microscopic detail and the report will be sent to the W.C.B.. However, prior to this report, the Pathology Institute will have available all medical information that the W.C.B. has on file which will be sent as soon as the W.C.B. is aware that an autopsy as outlined in Item 1 has taken place, and all reports are received.

4. Referral doctors will be sent all medical reports on file, including the autopsy report and hospital summary. They will then arrange to meet to discuss the claim fully.

5. The doctors will send a final report giving their opinion concerning what role the claimant's occupational lung condition played in his death and whether responsibility should be accepted by the W.C.B..

6. The Board should rely heavily on this aforementioned report regarding any decision concerning W.C.B. responsibility.

Reference:
Section 60(1)

Policy:
Eyeglasses damaged as the result of an accident arising from a worker's employment will be repaired or replaced. Generally, the eyeglasses must be worn at the time of the accident. The Board will not pay for glasses that are lost, broken or damaged as a result of actions of the worker.

General:
A. Eyeglasses will be repaired/replaced when glasses are being worn and the damage results from an accident arising out of and in the course of employment.

B. Eyeglasses may be replaced/repaired where:

   1. the damage results from excessive pitting from the use of electrical welding and/or sanding machines.

   2. damage results from putting on or taking off necessary safety equipment; that is goggles, helmets, etc.

   3. damage results from a hazard of employment; i.e., brushing away an insect, or other reflexive, protective movement.

C. Eyeglasses will not usually be repaired/replaced when damaged/broken when:

   1. damage results from the glasses falling from the worker's pocket.

   2. damage results from the glasses being dropped during routine cleaning, etc.

   3. damage results from the glasses falling from a worker's face without any accident; i.e., improperly fitted glasses.

D. Repair and replacement will be limited to the part(s) damaged in the work-related accident; i.e., if frames are damaged, frames will be repaired/replaced; if one lens is damaged, one lens will be replaced, etc.. Replacement will be of the same type, quality as was damaged.

E. The repairs/replacement must be done within three (3) months.

F. The maximum of $100 will be allowed for frames.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
CPP Disability Pension Cases
Code No: 10.15.1
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Policy:

We can provide information regarding our claimants to the C.P.P. authorities as per the guidelines listed below:

General:

1. Any such requests for medical information from the Canada Pension Plan should be under the signature of the applicant. Apparently they have a form "Authority to Disclose Medical Information" which they use for this purpose and which is signed by the applicant.

2. The Canada Pension Plan authorities should be advised in each case that any medical information, etc., is furnished as privileged information under our Statute and, therefore, is only furnished to them on a confidential basis.

3. Canada Pension Plan authorities should be advised that any medical information furnished is done so on a reciprocal agreement basis; i.e., we may request medical information from the Canada Pension Plan authorities on a specific claimant.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Lump Sum Commuted Value Settlement/Perm/Part/Disability
Code No: 10.16.1

The general policy and procedure in respect to lump sum or commuted value settlements in Permanent Partial Disability Cases under the provisions of Sections 41 and 42 should be as follows:

A. Where the assessment of Permanent Disability does not exceed 10% and where the commuted value monetary award amounts to $5,000.00 or to less, then the Permanent Partial Disability is to be settled on a Lump Sum or Commuted Value Basis.

B. Where the assessment of Permanent Disability does not exceed 10% and where the commuted value monetary award exceeds $5,000.00 then the claimant is required to elect a lump sum settlement or a Permanent Partial Disability Life Award payable monthly.

   Once the election is made, then the alternative chosen by the claimant is to be considered final and in full settlement for the Permanent Partial Disability as assessed.

C. Where the assessment of Permanent Disability exceeds 10%, then the Permanent Partial Disability award is not to be settled on a lump sum or commuted value basis but is to be paid as a monthly payment.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
'82 Amend Ch 43/Acts '75
S.31A: Death of a Claimant
Code No: 10.17.1

1. In respect to Section 31A (1) (amended October 15,1982), following the death of a claimant, this provides for a payment to the surviving spouse or dependents, of an amount equal to three times the monthly compensation that would have been payable to him had he lived.

2. In P.P.D. cases, three times the monthly award is paid to the surviving spouse or other dependents. The amount is paid only if there are dependents within the meaning of Section 1 (F). If there are no dependents, then an award is *Not Payable* to an Estate.

3. In P.T.D. cases, an amendment to the Act October 15, 1982, subsection 31A (2), in addition to any amount provided in Number 2 above, a further amount equal to nine times the monthly payment is paid to the surviving spouse or other dependents. The amount is paid only if there are dependents within the meaning of Section 1 (F). If there are no dependents, then an award is *Not Payable* to an Estate.

4. Where allowances are being paid for dependent children and when the death is adjudged to be compensable, i.e., widow and children's benefits are commenced from the date of death, then the three months' equivalent payments under subsection 31A (1) and the nine months' additional under subsection 31A (2) should only apply to the P.T.D. award and not to the children's allowances, otherwise the children would be paid for twice.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Coverage Police/Firemen Employed in off Duty Hours
Code No: 10.18.1

The following sets out the policy for coverage of members of police or fire departments, assessed by the W.C.B., employed in their "off duty" hours as special security, crowd control, etc..

1. Where such policemen or firemen carry out similar off duty employment and are assigned by and under the control of their respective departments, and in uniform, they are considered to be in the course of their employment, even though the remuneration is paid direct to the officers.

2. Where such policemen or firemen accept similar off-duty employment and these duties are *not* assigned by *nor* under the control of their department, they would *not* be considered to be in the course of their employment.

   In such instances the policemen or firemen would be considered as employees of the firm using their services and would be covered by this firm should it be assessed.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject
Guideline Claims Adjudication/Processing Claims General
Code No: 10.19.1

Policy:

1. All claims will be dealt with and adjudicated on in the first instance by the Director of Claims or his delegate. The Director of Claims and/or Claims Adjudicator, therefore, can decide in most cases as to reasonable compensable periods.

2. Any claim file for a decision or other action revolving on a medical matter should be referred by the Director of Claims or Claims Adjudicator to the Medical Department first. The Medical Officers will write their findings on a Form 51 for the guidance of the Claims Adjudicators. All the material on file will then be reviewed by the Claims Adjudicator before a decision with reasons is entered on the file.

3. New claims involving medical aid only or no compensable time-loss will be processed, adjudicated and allowed, if considered compensable, by the Director of Claims and his delegates within the scope of internal procedures and processing flow established by this policy within the Claims Department.

4. New claims, where compensable time-loss is indicated, will be processed, adjudicated and allowed, if considered compensable, by the Director of Claims and his delegates within the scope of internal procedures and processing flow established by the policy within the Claims Department. A claim summary sheet is to be raised for each compensable time-loss case.

5. However, cases occur in which new claims may be held up due to non-receipt of Form 6, 7, or 8. The following procedure is, therefore, approved for those cases where the documentation already received provided information that indicates that a compensable accident occurred.

   A. The Director of Claims or delegate is authorized to accept such claims for payment of compensation temporarily without full documentation as noted hereunder, using his discretion.

   B. Generally, a Form 7 should be received before a claim is approved for initial payment of compensation. However, in cases where employers are slow in furnishing Form 7 and where a Form 6 and Form 8 or other medical reports are on file, all of which indicate a compensable accident, then the claim will be adjudicated. In a Deposit Account, a Form 7 must be received before adjudication.

   C. In cases where a Form 6 and 7 have been received indicating a compensable accident with an extended lay-off likely, then the first payment can be made without a Form 8. In such cases a Form 10 should be forwarded at the time the first payment is made to ensure subsequent medical follow-up reports.

6. Where the Claims Department refers to the Members of the Board of Commissioners for decision, generally such referral should be by way of a Form 51 — Summary Report and Decision entry. The basis for the Board's decision should be written on the Form 51 and returned to the Claims Adjudicator of record.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Guideline Claims Adjudication/Processing Continuing Claims
Code No: 10.20.1

Policy:

1. Regardless of the probable period of disability, claims will be referred to the Medical Officers at intervals not exceeding three months. A Form 10 will be forwarded by the Claims Department as required. If it appears to the Claims Department that further information is needed before additional payment may be made, then the file is to be returned to the Claims Adjudicator of record for appropriate action.

2. Medical reports will be referred to the Medical Officers as necessary and returned to the Claims Adjudicator for adjudication. All specialists' reports are to be referred to the Medical Officers before adjudication.

3. In cases where a claim is closed on the information and medical reports then on file and where subsequent reports indicate a further short period of disability, such claims can be reopened and paid for the additional disability period as merited on the authority of the Claims Adjudicator.

4. **Re: Permanent Partial Disability**
The granting of a permanent disability indicates that the worker has a disability of a permanent nature and this implies that it could improve, remain stable of worsen. Flare-ups of such a condition can be considered for payment of T.T.D. if the medical evidence indicates that it is a recurrence of the compensable condition.

5. Whenever a Claims Adjudicator makes a decision regarding payment of W.C.B. benefits (close, continue, reduce, etc.) following review of the file by a Board Medical Officer, the Claims Adjudicator shall have his decision, with explanations for the decision, typed on a Form 51.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Guideline Claims
Adjudication/Processing
Medical Aid/Only
Code No: 10.21.1

Policy:

In Medical Aid Claims, the Employers Report of Accident will be requested. If not received within two weeks, and if the rest of the claim appears in order, the claim will be processed as if the Form had been received.

This does not apply to Federal or Provincial accounts — the Form must be received before these claims can be processed.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Guideline Claims Adjudication/Processing Perm Dis Award
Code No: 10.22.1

Policy:

1. Referral — the assessed disability is when a P.P.D. is being set, with the change that after the medical assessment is completed, if above is 15% disability, the file would be referred to the Permanent Disability Awards Committee consisting of the staff members delegated by the Board of Commissioners.

2. This Committee is to meet as needed to discuss claims that require further action, investigation, etc., before a final setting of the permanent disability award is made. Those that require no further action will be approved for payment.

3. The following criteria are to be reviewed in determining whether a worker is entitled to any permanent disability supplement.

   A. Total financial picture; i.e., income from sources other than Workers' Compensation, etc..

   B. Social Situation; i.e., marital status, number of dependents, age, etc..

   C. Education: i.e., what education he has and what potential he has to be re-educated.

   D. Location, taking into consideration employment opportunities within his own community.

   Claims will be referred to our Rehabilitation Department as soon as it appears that a worker will have a Permanent Disability. When the claim comes to the Permanent Disability Awards Committee, information concerning the above items #3 should already be on file and will provide the basis for any decision concerning a permanent disability awards supplement. The investigation to obtain the information should be conducted by the Rehab Department.

4. All Permanent Disability Award supplements are to be reviewed yearly until the age of 65.

5. Any supplementary award is to be paid as a separate cheque and will be sent at the same time as the pension cheques. The worker in effect will receive two cheques in two separate envelopes.

   Maximum supplementary award is $250.00 and the supplement cannot be given so as to award the claimant more than they would be entitled to if they were receiving 100% P.T.D.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject
Guidelines for Claims Adjudication and Processing-Review Committee & Appeal Procedures
Code No:10.25.1

Policy:

1. An internal Review Committee consisting of the Director of Claims, Assistant Director — Claims Adjudication and two Claims Supervisors will meet, when necessary, to examine claims that have been appealed.

2. Once the claim file is assembled or an old file brought forward for reappraisal, the Claims Adjudicator will determine its allowance or disallowance on a Form 51 and will communicate the decision with reasons to the claimant. If the claim is disallowed, the claimant will also be informed that there is further recourse to the Review Committee. The Review Committee may call in the claimant or may ask the Medical Department for further advice or may seek more information from the employer, etc., in order to assess the claim. If new information is submitted, the Claims Adjudicator can again review the claim.

3. If the decision of the Review Committee overrules the Claims Adjudicator in the claimant's favour, the Claims Adjudicator and the claimant are to be informed. If the Review Committee upholds the decision of the Claims Adjudicator, the claimant is notified with the reason(s) for the decision and advised that with further evidence he may resubmit his claim to the Claims Adjudicator of record.

4. If the claim is again disallowed with the additional information, he is to be advised of the reason(s) and informed that he may have recourse to the Review Committee.

5. If the claim is disallowed by the Review Committee, the claimant is informed of the reason(s) and advised that he may appeal to the Board of Commissioners.

6. If the claim is disallowed by the Board of Commissioners, the claimant is informed of the reason(s) with a copy of the Board of Commissioners' decision, and advised that he may appeal to the Workers' Compensation Appeal Board according to Section 159E of the Act. Also, that he may have a workers' counsellor assist him.

7. The Claims Adjudicator of record may be questioned at any stage of the proceedings, within the Board office.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Guideline Claims Adjudication/Processing Back Disability
Code No: 10.23.1

Policy:

Back Cases General

1. Traumatic back injury cases are adjudicated and processed in the normal general claims process.

   In cases with a history of traumatic back injury, then subsequent recurrence due to the accident injury is compensable, and claims can be reopened for recurrence.

2. Claims for back strains and/or sprains can be accepted if evidence indicates the problem arose from the job. There does not have to be trauma involved.

3. The general rule with regard to other than traumatic back cases is to consider reopening a claim if the further disability occurs within three to six months after the closing of the claim. Beyond this period, there must be a new incident or accident usually. However, it is not possible to establish a complete criteria in respect to these cases and each has to be dealt with on its own merits.

4. In disc cases, recurrence after about one year is doubtful, insofar as compensability is concerned, unless there is a new compensable incident. Adjudication has to be, particularly in these cases, considered in the light of Section 7 (2); i.e., the "aggravation factor". If a degenerative condition was present, then the claim would have been accepted on a limited liability basis in respect to the aggravation factor.

5. In the event of a permanent disability case, then further difficulty, particularly if disc surgery is involved, may warrant a reopening of the claim and further temporary disability considered on the basis of medical evidence.

6. In spondylolisthesis cases, the usual criteria for acceptance of a claim is that there must be trauma involved and such claims are, if accepted, usually accepted on a limited liability basis. If fusion is recommended, the opinion is that the spondylolisthesis is a developmental condition, and while responsibility may be accepted for surgery and compensation for a reasonable post-operative period, permanent disability in such cases is not usually compensable. An exception is where there is a combined procedure for removal of a disc and fusion, P.P.D. for the disc can be considered.

   Where subjective symptoms are present depending on the case, a claimant may be referred to a psychiatrist.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Volunteer Fire Department Coverage
Code No: 10.24.1
Page 1 of 1

Policy:

Volunteer Fire Department Coverage

Section 4(4) (c) of the W.C.B. Act is interpreted to mean that members of a volunteer fire department for whom coverage has been arranged, are considered in the course of their duties as from the time they arrive at the fire hall or reporting directly from their homes or employment to the fire, or fire hall when the alarm or phone sounds.

Coverage for Fire Service Generally

Again under the Section noted, firemen are covered and deemed to be in the course of their employment when delegated or required by a duly authorized official to take part in fire drills or fire tournaments.

It would appear that if a fireman is delegated to attend some meeting or other activity directly dealing with his requirements as a member of a volunteer fire brigade, that he would be considered on duty whilst performing such services *in Connection with Fire Matters*.

If an employee in general industry is delegated to attend a meeting, workshop, etc., in connection with his duties with the employer, he is considered covered and it does not appear that a concept of lesser coverage should probably be applied in a case of a volunteer fireman.

However, it is quite clear under Section 4(4) that when a volunteer fire department is admitted coverage, this coverage only extends to the members or persons certified by a municipal official.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Industrial Hearing Loss
Code No:20.1.1
Page 1 of 1

Reference:
Section 1 (i)

Policy:
Industrial hearing loss is recognized as an industrial disease and compensation for such hearing loss can be provided according to the criteria set out below.

General:
The criteria for dealing with such claims arising from continued industrial noise exposure over a period of time shall be as follows:

1. The acceptance of such claims where proven to be valid and where the disability is deemed to arise from industrial noise exposure is now considered to be permissive under the revised Section 1(i), and 139 (j). October 23,1984

2. Industrial loss of hearing in this regard must arise from an industrial process, trade or occupation wherein the noise exposure and hazard is characteristic of or peculiar thereto.

3. Where a claim is made in respect to industrial loss of hearing, it should be fully documented and referred to the Medical Officers to have the hearing loss evaluated and charted.

4. Temporary disability payments can only be recognized where time loss is directly due to the disability.

5. Permanent partial disability can be established on the basis on an audiogram and other medical evaluations and may be evaluated, rated, and assessed on this basis and a permanent partial disability award put into effect. Audiogram can be done and accepted for review after removal from the source of noise for at least 48 hours.

6. Permanent disability evaluation and assessments shall be made in accordance with the report of the committee on permanent disability evaluation to the Association of Workers' Compensation Boards of Canada dated September 1, 1986; and which Report and the Permanent Disability Rating Schedule contained in that report were adopted effective January 1, 1965, by resolution of the corporate Board made December 4, 1964, and as amended by resolution made July 14, 1966, in respect to revisions in the permanent partial disability 500, 1,000, 2,000, and 3,000 FR levels will be used.

7. Where a claim for industrial loss of hearing is established, whether accompanied by a loss of earnings capacity or not, a hearing aid may be authorized to be furnished as a Medical Aid provision if considered warranted by the Medical Officer of the Board.

8. To assist adjudicators in assessing hearing loss claims, it has been determined that we accept the worker's history of employment including whether or not he was exposed to "loud" noises on a regular and/or continuous basis. An "estimate" is to be made of the actual level of noise he would have been exposed to based on the information obtained from similar industries or type of work. Benefit of doubt is to be applied in favour of the worker for compensation.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Industrial Noise Levels
Code No: 20.2.1

Reference:
Workers' Compensation Act 1981, Section 73 — Hearing Loss

Policy:
Hearing loss claims will be considered when noise exposure exceeds the levels adopted by the Department of Labour.

General:
Permissible Noise Exposures (Steady—State Noise)

Maximum Period of Exposure (Hours per 24 hours)	Steady—State Noise Level (dBA)
16	80*
8	85*
4	90*
2	95*
1	100*
0.5	105*
0.25	110*
0.125	115*

*No exposure to steady—state noise in excess of 115 dBA is permitted, as determined by the N.S. Department of Labour Occupational Health and Safety.

Permissible Noise Exposure (Impulse of Impact Noise)

Permitted Number of Impulses or Impacts per 24 Hours	Sound Level (dBA)
0	Above 140*
100	140
1,000	130
10,000	120

*No exposure to impulse or impact noise in excess of 140 decibels peak sound pressure level is permitted, as determined by the N.S. Department of Labour Occupational Health and Safety.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Spinal Fusion Second Opinion
Code No:20.3.1
Page 1 of 1

Reference:
Workers' Compensation Act 1981, Medical Aid

Policy:
The Board will only accept responsibility for spinal fusions and repeat spinal operations when the following criteria have been met.

General:
1. **Repeat Spinal Surgery**
   The Board requires a second opinion of its choice in all cases in which repeat spinal surgery for any condition is being considered.

2. **Spinal fusions**
   The Board requires a second opinion of its choice in all cases in which a spinal fusion is to be done for conditions other than a spondylolisthesis. No second opinion is necessary regarding spondylolisthesis as long as this is a first spinal operation.

   In these instances the second opinion must be in agreement with the proposed treatment in order for the Board to accept responsibility for the medical aid costs.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Fee Schedule Second Opinion Spinal Surgery
Code No:20.4.1

Reference:
Workers' Compensation Act — Medical Aid Fee Schedule for Second Opinions that Relate to Spinal Surgery

Policy:
In those cases where the W.C.B. requires a specialist consultation to give a second opinion regarding a repeat spinal operation or spinal fusion, there are often lengthy histories of previous consultations and investigations which must be reviewed, requiring a considerable amount of work beyond the usual time involved for a general orthopaedic consultation.

General:
The W.C.B. uses the services of all specialists but has the right to use the specialist of its choice in each individual case.

The W.C.B. will pay a fee equivalent to 50 units for second opinion consultations on repeat spinal operations or spinal fusions from the specialist of its choice.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject
Home Breathing Machines
Code No: 20.5.1
Page 1 of 1

Reference:
Workers' Compensation Act 1981 — Medical Aid

Policy:
The Board accepts responsibility for purchasing home breathing machines for claimants with occupational lung diseases and under Section 9A of the Act, when the following criteria are met.

General:
1. These machines will only be accepted by the Board if they are recommended by a recognized Respirologist.

2. These machines will only be purchased for the treatment of obstructive lung disease and not for restrictive lung disease or for a diffusion defect.

3. In cases where the obstructive lung disease is only partly compensable, it will have to be ascertained if a significant degree of the airway obstruction is occupational before the Board will accept responsibility (this will be ascertained after full review of all facts, etc.)

4. These machines will be supplied on a loaned basis only and will be returned to the Board when their use is completed.

   This is to be authorized by the Medical Department.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Acupuncture Treatment
Code No: 20.6.1
Page 1 of 1

Reference:
Workers' Compensation Act 1981, Medical Aid

Policy:
Acupuncture treatment will be accepted by the W.C.B. under the following criteria.

General:
1. Acupuncture treatment will only be accepted if carried out in a Pain Clinic setting and by physicians with training in this field.

2. There must be a referral to the Clinic from the treating physician.

3. The procedural fee will be $10.00 per treatment irrespective of whether electrical, thermal or manual stimulation is utilized.

4. Generally, the Board will only pay for a maximum of ten treatments. Additional treatments may be considered upon request.

5. No treatments will be accepted for acute or chronic low back pain.

Reference:
Workers Compensation Act 1981, Medical Aid

Policy:
Chemonucleolysis will be accepted by the W.C.B. when the following criteria are met.

General:
1. The treatment must be carried out in a hospital setting by a specialist qualified in this particular procedure, neurosurgeon or orthopaedic surgeon.

2. The patient has been given a minimum of three weeks conservative treatment prior without improvement. This may be in the form of bed rest, medication, back bracing, physiotherapy, etc..

3. There is clinical evidence of nerve root irritation or deficit which preferably is supported by a positive myelogram or C.T. scan or epidural venogram.

The Board accepts no responsibility for this treatment if there is:

1. A history of previous spinal surgery;

2. The presence of spinal stenosis, myelographic block, cauda equina compression, severe spondylolisthesis or acute paralysis;

3. Myelographic evidence of only bulging discs associated with only back pain and no nerve root deficit.

The Board expects that all patients who satisfy the criteria for this treatment will be adequately educated regarding not only its potential benefits but its possible side effects.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject
Photocopying of Claimants Files
Code No.20.8.1
Page 1 of 1

Reference:
Section 149, Subsections (3), (4)

Policy:
A file will be copied only once and provided free of charge to the claimant or the claimant's representative. The written request will be placed on the claimant's file. Subsequent information in the same file(s) will be copied, if required.

It is the responsibility of the person requesting the information to make sure that the copied file(s) is transferred when and if the claimant chooses a new representative.

All written requests are to be addressed to: Workers' Compensation Board, 5668 South St., Box 1150, Halifax, N.S. B3J 2Y2.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Physiotherapy Treatment
Code No: 20.9.1

Reference:
Workers' Compensation Act 1981, Medical Aid

Policy:
Physiotherapy treatment will be accepted by the W.C.B. under the following criteria.

General:
1. Physiotherapy prescribed by the treating physician may be continued without prior authorization from the Board, up to a maximum of *eight* weeks per case.

2. Such physiotherapy treatment shall not exceed two treatments per day.

3. Such physiotherapy shall be rendered by a physiotherapist at a Centre which has been approved by the Workers' Compensation Board.

4. It is understood that the physician and the physiotherapist will be in communication regarding treatment progress.

5. In cases where it is considered that physiotherapy should continue beyond eight weeks, prior authorization must be obtained from the Board's Medical Department or the Medical Aid Division or by the attending physician or physiotherapist. This may be done by writing or telephoning the Board.

6. In general, any communication by the physiotherapist to the Board should go through the physician, unless special circumstances indicate otherwise.

7. Upon approval, authority shall be given for extension of physiotherapy for individual intervals of *four weeks each*. The total accumulative treatment shall not exceed sixteen weeks per case.

8. Any case requiring physiotherapy treatment in excess of sixteen weeks (total accumulative amount) shall be referred to the Board's Medical Director for consideration of approval to continue beyond this interval.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Transcutaneous Nerve Stimulators
Code No:20.10.1

Reference:
Workers' Compensation Act 1981, Medical Aid

Policy:
Transcutaneaus Nerve Stimulators will be accepted by the W.C.B. under the following criteria.

General:
1. These units may be prescribed by the family doctor, a specialist or a physiotherapist in consultation with the treating physician.

2. Whether rented or bought, these units continue to be the property of the Board and there must be prior authorization from the Board before any responsibility is accepted.

3. These units will not be authorized for rental or purchase until there is a trial of use with the make and model to be prescribed.

4. These units will not be authorized to anyone who is undertaking active treatment or is being considered for more specific treatment. The claimant, therefore, should be at or near a plateau regarding recovery from his compensable injury.

5. Requests for a change of unit must undergo a trial as per No. 3.

6. In claims where there is no P.P.D. entitlement, these units will be returned to the Board within three months after the claim is closed.

7. If all criteria are met, units may be authorized by Medical Aid Division.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Treatment: Pain Clinic
Code No: 20.11.1

Reference:
Workers' Compensation Act 1981, Medical Aid

Policy:
Treatment at the Victoria General Hospital Pain Clinic will be accepted under the following criteria.

General:
1. Treatment at the Pain Clinic will not be accepted without prior authorization from this Board. This should be requested through the Medical Aid Department.

2. The initial period of treatment will be a maximum of six weeks only. This period will not be considered to have begun until the actual treatment is initiated.

3. An additional four week period may be granted upon request from the Pain Clinic to the Board's Medical Department, in which there should be evidence and information to indicate that such further treatment will be of significant and lasting benefit to the claimant.

4. Requests for repeat referrals to the Pain Clinic will be handled in the same way as the initial referral after a minimum period of three months has elapsed.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Home Oxygen Therapy
Code No: 20.12.1

Reference:
Workers' Compensation Act 1981, Medical Aid

Policy:
Home oxygen therapy will be provided for claimants with occupational lung diseases and under Section 9A of the Act, when the following criteria are met.

General:
1. This treatment must be recommended by a qualified chest specialist.

2. The medical criteria for such use is properly documented.

This is to be authorized by the Medical Department.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Portable Home Oxygen Therapy
Code No: 20.12.2

Reference:
Workers' Compensation Act 1981, Medical Aid

Policy:
Portable home oxygen therapy will be provided for claimants with occupational lung diseases and under Section 9A of the Act, when the following criteria are met.

General:
1. The need for this treatment is directly related to the claimant's compensable pulmonary condition.

2. This treatment is recommended by a qualified chest specialist.

3. Individuals being considered for such treatment must be considered to be reasonably active and that with the use of this particular type of oxygen therapy they are indeed able to get out of the house and engage in a moderate amount of outside activities.

   This is to be authorized by the Medical Department.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Epidural Analgesia and Paravertebral Blocks
Code No: 20.13.1

Reference:
Workers Compensation Act, 1981, Medical Aid

Policy:
The W.C.B. accepts responsibility for epidural analgesia and paravertebral blocks for low back pain as per the following criteria.

General:
1. Referrals may be made by an Orthopaedic Surgeon, Neurosurgeon, Neurologist or Psychiatrist.

2. Qualified Anaesthetists are usually the persons to whom these problems are referred for the procedure. Practitioners in the referring specialties mentioned above may carry out the procedures if they have an interest in them.

3. These procedures may be either diagnostic or therapeutic with the intention of breaking self-perpetuating cycles of chronic pain.

4. Proper consultations and reports are required for payment of the appropriate fee.

5. No more than three consecutive treatments are accepted unless there is a written request which receives the authorization of the Board.

6. These procedures may be carried out in the overall management at a Pain Clinic and in these circumstances the need for referral from appropriate specialists does not apply.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Lead Poisoning
Code No: 20.14.1

Reference:
Workers' Compensation Act 1981, Section 73 and Schedule A, Industrial Diseases

Policy:
Lead poisoning cases will be considered as per the following criteria.

General:
The W.C.B. after having reviewed current information on lead poisoning states that claims for lead poisoning be accepted with the blood levels in excess of 4 u moles/Litre and that compensation be continued until the blood lead level falls below 3 u moles/Litre.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Lung Cancer Foundry Workers
Code No: 20.15.1
Page 1 of 1

Reference:
Workers' Compensation Act 1981, Section 73 and Schedule A, Industrial Diseases

Policy:
Lung cancer in foundry workers will be considered under the following guidelines.

General:
1. Primarily lung cancer in certain foundry workers shall be accepted as an industrial disease under Section 73 of the Act as peculiar to and characteristic of a process, trade or occupation involving exposure to foundry aerosols within a foundry unit.

2. Based on medical studies,a review of past foundry conditions and analysis of claims reported to the Board, cases of primary lung cancer shall be favourably considered when the following appropriate combinations of circumstances regarding exposure, latency and cessation factors apply:

   2.1 Twenty years of minimum exposure within and ferrous foundry unit where the following conditions prevail —

      2.1.1 Predominant use of sand moulds;
      2.1.2 'Floor pouring' of castings;
      2.1.3 Evidence that ventilation has been less than satisfactory as determined by a review of records of the Ministry of Labour surveys (for silica) and/or historical data;

   2.2 The cessation interval (time between cessation of occupational risk and appearance of lung cancer) in a smoker shall be 15 years or less. (See definition next page)

   2.3 The cessation interval in an ex-smoker or confirmed non-smoker shall be 20 years or less. (See definition next page)

3. Claims which do not meet the criteria in Section 2 (including those from nonferrous foundries) shall be individually judged on their merits taking into consideration the variations in intensity and duration of exposure. The benefit of doubt applies.

Definition of Smoking

1. **Non-smoker**
   A never smoker. A person who has never smoked even occasionally.

2. **Ex-smoker**
   A person who has smoked during his lifetime but who has not smoked for the past ten or more years.

3. **Smoker**
   A person who currently smokes, or who has ceased smoking for less than the previous ten years.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Lung Cancer in:
Asbestos Workers
Code No: 20.16.1

Reference:
Workers' Compensation Act 1981, Section 73 and Schedule A, Industrial Diseases

Policy:
Lung cancer in asbestos workers will be considered under the following guidelines.

General:
1. Lung cancer in asbestos workers is to be accepted as an industrial disease under Section 73 of the Act as peculiar to and characteristic of a process, trade or occupation involving exposure to asbestos.

2. Based on medical studies, lung cancer claims should be favourably considered when the following circumstances apply:

   2.1 There is a clear and adequate history of at least 10 years occupational exposure to asbestos;

   2.2 There is a minimum interval of 10 years between first exposure to asbestos and the appearance of lung cancer.

   2.3 Claims which do not meet the guidelines in 2.1 and 2.2 should be individually judged on their own merit having regard to the intensity of exposure and other factors peculiar to the individual case. The benefit of reasonable doubt applies.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Mesothelioma in Asbestos Workers
Code No: 20.17.1
Page 1 of 1

Reference:
Workers' Compensation Act 1981, Section 73 and Schedule A, Industrial Diseases

Policy:
Mesothelioma in asbestos workers is to be considered under the following guidelines.

General:
Based on medical studies, mesothelioma claims are to be favourably considered when the following circumstances apply:

1. There is a clear and adequate history of at least 10 years occupational exposure to asbestos;

   and

2. There is a minimum interval of 15 years between first exposure to asbestos and the appearance of mesothelioma;

3. Claims which do not meet the guidelines in (1) and (2) should be individually judged on their own merit having regard to the intensity of exposure and other factors peculiar to the individual case. Consideration will be given where it seems evident that the mesothelioma cancer resulted from occupational exposure to asbestos. The benefit of reasonable doubt applies.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Laryngeal Cancer/ Asbestos and Nickel Workers
Code No: 20.18.1

Reference:

Workers' Compensation Act 1981, Section 73 and Schedule A, Industrial Diseases

Policy:

Claims for laryngeal cancer in industry related to asbestos exposure and nickel exposure are to be considered under the following guidelines.

General:

1. Laryngeal cancer in workers occupationally exposed to asbestos fibre and/or to nickel aerosol in specific industrial processes will be accepted as an industrial disease under Section 73 (3) of the Act.

2. Based on medical studies, claims for laryngeal cancer will be favourably considered under the following circumstances:

   2.1 Any industrial process in the nickel industry which produces nickel in aerosol dispersion whether in combined or elemental form. This may include the following:

   - Roasting
   - Welding
   - Smelting
   - Refining
   - Electroplating

   2.2 Any occupation in which there is a clear and adequate history of occupational exposure to asbestos dust, and while such occupational exposure cannot be quantitatively described, it should be of continuous and repetitive nature and should represent or be a manifestation of the major component of the occupational activity.

3. **Duration of Exposure**

   3.1 Nickel: an accumulative minimum of 15 years exposure to nickel aerosols as defined in 2.1

   3.2 Asbestos: an accumulative minimum of 10 years proven exposure as defined under 2.2

   3.3 Nickel and asbestos: an accumulative minimum of 7.5 years nickel as well as 5 years asbestos exposures in the case of dual exposure.

4. **Inception Period**

   4.1 Nickel: this shall be a minimum of 20 years from the commencement of the first hazardous exposure;

   4.2 Asbestos: this shall be a minimum of 20 years from the commencement of the first hazardous exposure;

   4.3 Nickel and Asbestos: this shall be a minimum of 15 years from the commencement of the first hazardous exposure.

5. Claims which do not meet the guidelines should be individually judged on their own merit having regard to the intensity of exposure and other factors peculiar to the individual case. The benefit of reasonable doubt applies.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Eligibility
Code No:30.1.1
Page 1 of 1

Reference:

Workers' Compensation Act 1968, Section 72 Policy Manual 1983, Code No. 4.1.1 & 4.2.1

Policy:

The Rehabilitation Department will co-ordinate and assure the most efficient and timely delivery of the multiple services often necessary to restore the occupationally injured claimant to a state of employability as near as possible to that which the claimant had prior to the injury or disease.

General:

Eligibility Criteria

Vocational Rehabilitation Services may be extended to a worker:

1. Whose compensable permanent disability prevents a return to the usual occupation.

2. Who is temporarily disabled due to a compensable condition and receiving compensation benefits even though there is no indication of permanent disability. The worker must co-operate in a medical and/or vocational rehabilitation process and actively seeking employment.

3. Who suffers from an industrial disease requiring a change of employment.

4. Whose usual employment could cause a recurrence or aggravation of the compensable condition.

Policy:

Vocational Rehabilitation Services may not normally be extended to a worker:

1. Who does not have an approved claim.

2. Who inflicts physical violence or who threatens physical violence on a Rehabilitation staff member.

3. Who fails to accept suitable employment which is available and is determined to be within the worker's interests, skills, capabilities, and is considered to be realistic in terms of existing socio-economic conditions.

4. Who has received extensive vocational rehabilitation service without benefit to the individual and where there is no evidence to indicate a change in response to counselling or a willingness to co—operate.

5. Who is medically capable of returning to usual occupation.

6. Who relinquishes employment of own volition without just cause.

Policy:

Vocational Assessment
Vocational and/or psychological testing can be carried out at the Nova Scotia Rehabilitation Centre and/or the Department of Social Services on a fee for service basis.

Industrial Assessment
Assessment in an actual work environment which may lead to training on the job and/or placement of the worker in gainful employment.

General:

Authorization for assessment must be fully documented and, where applicable, submitted with supportive medical evidence.

All authorizations and conditions must be communicated in writing to the worker, trainer, agency, and where applicable, other interested parties

Relevant Factors
The assessment has been thoroughly evaluated and is deemed to be essential to the furtherance of the worker's rehabilitation.

The worker has been advised concerning the level and duration of benefits while on assessment, e.g., weekly maintenance, accommodation, and/or transportation allowances, etc.

The worker, trainer, and/or agency have been informed of their responsibilities concerning regular attendance and the method of reporting absence from the assessment.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Guideline Claims Adjudication/Processing Dis Assess Comm
Code No: 30.3.1
Page 1 of 1

Policy:

1. This committee of three staff members, delegated by the Board of Commissioners and designated as the Disability Assessment Committee, will review claims that have been channeled from the Claims Adjudicator. When possible, rehabilitation and/or pension decisions may be indicated from the information contained on the files.

2. The Disability Assessment Committee is to review claims and decide if further action is warranted utilizing the services of the Rehabilitation Department when necessary.

3. The Committee is empowered to extend disability payments for some rehabilitation.

4. The request for compensation payment extension is to come from the Director of Rehabilitation documented with reason(s) to the Committee, subject to the policies of the Board.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Continuous Coverage/ Less Than Three
Code No 40.1.1
Page 1 of 1

Reference:
Regulations 3(2)(3) maintain that an employer shall continue to be under Part 1 until notice is received stating that the industry has ceased to carry on.

Policy:
If an employer registers under compulsory coverage regulations, i.e., has more than two workers and reduces his workforce to less than three, it has been our procedure to continue coverage until there are no workmen employed at all.

Companies who employ less than three do not have to register, but those who have had three and reduce their workforce to two must continue to pay.

Employers who have less than three workers may cancel coverage by requesting same in writing to the Board. Cancellation to be effective the date correspondence is received and employer must pay premium up to that date. Account would have to be audited to ensure the accuracy of the employer's statements.

This policy will not apply to seasonal employers whose work force fluctuates and diminishes because of the nature of business.

Conditional on cancellation would be the employers' and employees confirmation, in writing, to the Board that all employees were advised of cancellation of coverage.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Special Protection Employer/Partner
Code No: 40.2.1
Page 1 of 1

Reference:
Section 4(2).

Policy:
When an employer or partner applies for special protection under the Act, coverage is made effective the date the application and full payment of the assessment is received.

The assessment premium will be based on the total annual amount elected by the applicant and not prorated for part of a year.

The Board requires the applicant to have a medical examination prior to approval of application.

Employers and partners must also have to renew their coverage annually and if this is not done, it will automatically be cancelled.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Backdating Coverage
Code No: 40.3.1
Page 1 of 1

Reference:
Regulation 2, Section 1(b) provides that employers who have three workers must come under Part 1 of the Act.

Policy:
When an employer is deemed to fall under the regulations and fails to report his operations to the Workers' Compensation Board the format for backdating coverage is as follows:

> The assessment is backdated either to the 1st date more than three were employed, or three years from January 1st of the current year — whichever is less.

Regulation 7, Section 3 provides that such failure to report such an operation is subject to a 5% penalty. This 5% is calculated on the assessment due for the period backdated and is charged in all cases.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Status Letters Requests from Lawyers
Code No: 40.4.1
Page 1 of 1

Reference:
Requests from lawyers regarding the credit worthiness of clients/employers. Confirmation that the employer is not subject to lien under Section 98 or 125 of the Workers' Compensation Act.

Policy:
The criteria for issuing the above letters will be as follows:

- If the account is paid and all forms are in, i.e., Payroll Statements, letters may be issued.
- If the balance owing is less than $100.00 the letter may be given at the discretion of the Director of Assessment & Collections.
- If the account has a good payment history and there have been no "NSF" cheques in the last three years, status letters may be issued not to exceed four months from the date of issue.

Postdated Cheques
If the postdated cheque payment schedule exceeds four months, then no letters will be issued.

Whenever we have a request for status letters and the company has arrangements for payment via postdated cheques, the status letter should be given for a period of thirty days.

New Accounts
Where we have new accounts that are not successors to accounts that were previously bad accounts, status letters may be issued up to the date of the assessment.

If the new account is a successor to a previously bad account, it would have to be paid in full before any letters are issued.

Letters Prior to February 28th
If a letter is requested between January 1st and February 28th and the payroll information is in the file from the previous year and there will be a balance owing, this must be paid before letters will be issued.

Excluded Accounts
All excluded accounts must be paid in full, regardless of the due date, before any letters are issued.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
"NSF" Cheques
Code No.40.5.1
Page 1 of 1

Reference:
A cheque has been applied to an account and is returned by the bank "non sufficient funds".

Policy:
When we are successful in obtaining a certified cheque for an "NSF" cheque, a $20.00 charge will be applied to the account to cover our expense for certification.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Postdated Cheques
Code No: 40.6.1

Reference:
Periodic payment of assessments, Section 94 of the Workers' Compensation Act — P.D.C.

Policy:
Our policy for accepting postdated cheques is as follows:

1. Provided a company meets our criteria in accepting postdated cheques, we will require 25% of the balance owing immediately.*
2. The balance to be paid by postdated cheques in multiples of no more than four: $101.00 to $399.00 — three cheques $399.00 and over — four cheques
3. 2% will be added to the principal payment.
4. One "NSF" cheque nullifies agreement and full assessment is due and payable on demand.
5. Clearance/status/lease letters will not be issued if PDCs do not pay full balance and/or exceed four cheques.

Any deviations from this policy will be at the discretion of the Supervisor of Collection Services, or Director of Assessment & Collections.

***Criteria for Accepting Postdated Cheques**

1. Balances under $100.00 do not qualify.
2. History of "NSF" cheques within the last twelve month period does not qualify.
3. All accounts should be included in payment calculations.
4. Full balance should be paid, including provisions for deferred payment assessment.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Clearance Letters
Code No: 40.7.1

Reference:

Clearance letters are issued so that principal contractors are aware that their sub-contractors are paid and in good standing.

Policy:

Clearance Letters

In Good Standing

If the following criteria is met, a four month clearance will be issued.

1. Account is paid including all cross indexes as well as cross reference accounts and all forms are in, i.e., Payroll Statement.
2. Account has postdated cheques on file paying full balance not exceeding four months, with no history of "NSF" cheques (last twelve month period).
3. Account with a balance of $100.00 or less.

***Not In Good Standing**

If the following applies to an account, the four month clearance will not be issued:

1. Past due balance over 100.00.
2. Postdated cheques on file exceeding four months and/or does not pay full balance or an "NSF" cheque history.
3. Payroll Statement not up to date.
4. Excluded and/or suspended files.
5. Judgement and/or bankruptcy files.
6. New account that was a successor to a previously bad account.
7. Cross indexes/cross reference accounts not paid.
8. If Payroll Statement filed and balance not paid from previous year even though not due.

*If any of these are overruled by the Director of Assessment & Collections, or Supervisors, this is to be documented as to why in writing in the file.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Rental Agreement: Rental Association of Canada
Code No: 40.8.1

Reference:
Lien may be created under Section 125 of the Workers' Compensation Act.

Policy:
Members of the Rental Association of Canada have been given an exemption from our lien under Section 125.

The wording of the exemption is:

The Workers' Compensation Board agrees to provide an exemption for all goods that are on a normal rental contract.

This will be inclusive, regardless of the size or value of the goods rented.

This will apply to members of the Rental Association of Canada only.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Coverage of Wives and Member of Family
Code No: 40.9.1

Reference:
Assessment coverage for wives and members of a family come under Section 99 (1)(2).

Policy:
1. **If the employer is an incorporated company.**

   Wives and members of a family that *are shown* on the payroll
   - not active
   - active
   - not assessable
   - assessable

2. **Not shown** on payroll but active: assessable at fair estimate on degree of activity.

3. **If the employer is a proprietorship or partnership**
   Wives and members of family shown on the payroll active or not active: assessable.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Coverage Volunteer Fire: Course of Their Employment
Code No: 40.10.1

Reference:
Volunteer Fire Departments — Section 4(3)(4)(a)(b)(c)(d)(e)

Policy:
The Workers' Compensation Board has reviewed Section 4(4)(c) of the Workers' Compensation Act and have ruled that the interpretation of "in the course of their employment" include:

(a) from the time they arrive at the fire hall; or

(b) reporting directly from their homes or employment to the fire or fire hall, when the alarm or phone sounds

Coverage for Fire Service Generally
Again under the Section noted, firemen are covered and deemed to be in the course of their employment when delegated or required by a duly authorized official to take part in the fire drills or tournaments.

It would appear that if a fireman is delegated to attend some meeting or other activity directly dealing with his requirements as a member of a volunteer fire brigade, that he would be considered on duty whilst performing such services *in connection with fire matters.*

If an employee in general industry is delegated to attend a meeting, work shop, etc., in connection with his duties with the employer, he is considered covered and it does not appear that concept of lesser coverage should probably be applied in a case of volunteer firemen.

However, it is quite clear under Section 4 (4) that when a volunteer fire department is admitted for coverage this coverage only extends to the members or persons certified by a municipal official.

If a person is requested or ordered by the Fire Chief to assist them in fighting a fire, would they be covered?

The Board has ruled that in the event of a claim in such circumstances, the name of such claimant could be submitted as an addition to the existing list of members and signed by an authorized official of the Municipality.

The claim could be further supported by a letter outlining the circumstances, signed by the Fire Chief.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject
Coverage Police/Firemen Employed in off Duty Hours
Code No:40.11.1
Page 1 of 1

The following sets out the policy for coverage of members of police or fire departments, assessed by the W.C.B., employed in their "off duty" hours as special security, crowd control, etc..

1. Where such policemen or firemen carry out similar off duty employment and are assigned by and under the control of their respective departments, and in uniform, they are considered to be in the course of their employment, even though the remuneration is paid direct to the officers.

2. Where such policemen or firemen accept similar off-duty employment and these duties are *not* assigned by *nor* under the control of their department, they would *not* be considered to be in the course of their employment.

   In such instances the policemen or firemen would be considered as employees of the firm using their services and would be covered by this firm should it be assessed.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Separation of Office in Industry
Code No:40.12.1

Reference:
An office of a company that is an assessed employer is incidental to the main operation. Section 2(1).

Policy:
A company is classified and assessed on its main operation with all other work as incidental. For assessment purposes there is no separation between the office staff and the main group of employees.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Standby Workers
Code No: 40.13.1

Reference:
Standby workers are employees who are on twenty-four hour call

Policy:
Companies who have employees that are required to be on 24 hour call and in some cases at home when they get the call to go to work, must make prior arrangements with our office.

This information is documented in the assessment file and we will extend coverage from the time they leave their home until they arrive at the place of employment.

In no cases, will a situation like this be covered "after the fact", the scenario must be documented *prior* to coverage being made available.

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Policy Statement
Workers' Compensation
Board of Nova Scotia

Subject:
Coverage of Farm Workers
Code No:40.14.1
Page 1 of 1

Reference:

Most farming operations have employees who do work other than farming.

Policy:

Employers engaged in the business of fur ranching, pig or poultry production, Christmas tree production or general farming, have coverage under the Workers' Compensation Act for their regular workers when carrying out work other than their assessed industry, provided such work does not exceed 15% of the annual payroll.

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Policy Statement
Workers' Compensation Board of Nova Scotia

Subject:
Appealing Assessment or Classification
Code No: 40.15.1

Reference:
Criteria for appealing assessment and the process of appeal assessment matters.

Policy:
Assessment or Classification Appeals
If an employer feels that the assessment and/or classification is incorrect, an appeal may be presented.

Before an appeal will be entertained, the assessment currently owing in the account must be paid.

When that is done, then the appeal process will be initiated through proper channels.

Appeal Process
If a worker or employer wishes to appeal a decision related to an assessment matter, the appeal is referred to the person who made the original decision.

If additional information is submitted, which might affect the decision on an issue being raised, but was not considered in the original decision, the matter is to be reconsidered.

The case would then be discussed with the Director of Assessment & Collections and his decision conveyed to the employer.

If the employer is not content with the decision at that level, the history and documentation may be presented to the Assessment Committee for review, and as a final appeal to the Board of Commissioners.

Policy Statement
Workers' Compensation Board of Nova Scotia

Reference:
Section 89 (4) of the Act provides that the Board may assess a shareholder who is active in the business by setting a reasonable salary figure for such activity.

Policy:
The minimum amount set for this activity in the absence of proper income proof is set at not less than the minimum base rate and not more than the maximum assessable earnings

Report
of

The Committee on Permanent Disability Evaluation

to

The Association of Workmen's Compensation Boards of Canada

September 1, 1964.

Romeo Depeyre, M.D.
Quebec Workmen's
Compensation Board

C. R. Salsbury, M.D.
B. C. Workmen's
Compensation Board

D. Lees, M.D. C.M.O.
Manitoba Workmen's
Compensation Board

D. E. Bell, M.D. Secretary

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Permanent Partial Disability

Rating Schedule

The schedule is designed to show in percentage the approximate impairment of earning capacity in an average unskilled workman.

It should be used only as a guide always having regard to whether the award adequately compensates the workman for his loss of earning capacity either at his own of some other suitable occupation.

In off-schedule of "judgement" ratings awards should be proportionate to listed items.

Upper Extremity

Amputations	Percentage
1. Proximal third of humerus or disarticulation at shoulder	70
2. Middle third of humerus	65
3. Distal third humerus to biceps insertion	60
4. Biceps insertion to wrist (depending on usefulness of stump)	50 - 60
5. Thumb	10
6. Thumb, including metacarpal	20
7. Thumb, one phalanx	5
8. Fingers, all four	30
9. Fingers, four at P.I.P	18
10. Fingers, four at distal	9
11. Finger, index	4
12. Finger, index at P.I.P	2.4
13. Finger, index at distal	1.2
14. Finger, middle	4
15. Finger, middle at P.I.P	2.4
16. Finger, middle at distal	1.2
17. Finger, ring	2.5
18. Finger, ring at P.I.P	1.5
19. Finger, ring at distal	.8
20. Finger, little	2.5
21. Finger, little at P.I.P	1.5
22. Finger, little at distal	.8
23. Metacarpals (except thumb)	*Add value of finger*
24. Fingers, index, middle and ring	22
25. Fingers, index, middle and little	22
26. Fingers, index, ring and little	19
27. Fingers, middle, ring and little	19
28. Fingers, index and middle	14
29. Fingers, index and ring	11
30. Fingers, index and little	11
31. Fingers, middle and ring	11
32. Fingers, middle and little	11
33. Fingers, ring and little	8
34. Fingers, two or more at P.I.P	*6/10 combined value*
35. Fingers, two or more at distal	*3/10 combined value*
36. In amputation or impairment of all or part of thumb and amputation or impairment of all or parts of one or more fingers, add the lesser ratings as an enhancement factor.	

Immobility of Joints	Percentage
37. Shoulder, without either articular or scapular movement (the so-called "frozen shoulder")	35
38. Shoulder joint (gleno-humeral) ankylosed but with full scapular movement	15
39. Shoulder, abduction limited to 90 but with good rotation and pivotal movement	5

40. Elbow 20
41. Wrist 12.5
42. Pronation and supination, complete in mid-position 10
43. Pronation alone 3
44. Supination 5
45. Thumb, both joints 5
46. Thumb, distal joint 2
47. Finger, all joints ..... *Up to value of finger*
48. Finger, P.I.P. and distal joints ..... *Up to 6/10 value of finger*
49. Finger, distal joint ..... *Up to 3/10 value of finger*

Lower Extremity

Amputations **Percentage**

50. Hip disarticulation or short stump requiring an ischeal bearing prosthesis 65
51. Thigh, seat of election 50
52. End bearing knee or short below knee stump not suitable for a conventional B.K. prosthesis 45
53. Leg, suitable for B.K. prosthesis 35
54. Leg, at ankle, end bearing 25
55. Through foot ..... 10 - 25
56. All toes 5
57. Toe, great 2.5
58. Toe, great at distal 1
59. Toes, other than great, each 5

Immobility of Joints **Percentage**

60. Hip 30
61. Knee 25
62. Knee, flexion limited to 90 5
63. Ankle 12
64. Great toe, both joints 2.5
65. Great toe, distal joints 5

Shortening of Leg **Percentage**

66. 1" 1.5
67. 2" 6
68. 3" 15

Denervation **Percentage**

69. Peroneal, complete 12
70. Median, complete at elbow 40
71. Median, complete at wrist 20
72. Ulnar, complete at elbow 10
73. Ulnar, complete at wrist 8

Impairment of Vision **Percentage**

74. Enucleation 8
75. Sight of one eye 16
76. Cataract or aphakia 12
77. Double aphakia 20
78. Hemianopia, right field 25
79. Hemianopia, left field 20
80. Diplopia, all fields 10
81. Scotomata, depending on location and extent ..... Up to 16

Note: In rating a cataract at 12 % it should be reasonably certain there is no fundus pathology.

Partial Visual Loss	Percentage
82. 20/30	0
83. 20/40	1
84. 20/50	2
85. 20/60	4
86. 20/80	6
87. 20/100	8
88. 20/200	14
89. 20/400	16

Note: Snellen test for distance after correction with conventional lenses.
For bilateral visual impairment see page 21.

Impairment Of Hearing	Percentage
90. Deafness, complete in one ear	5
91. Deafness, complete in both ears	30

Partial Hearing Loss Where Both Ears Are Affected

92. 35 decibels in single ear	.4
93. 40 decibels in single ear	.7
94. 45 decibels in single ear	1.0
95. 50 decibels in single ear	1.4
96. 55 decibels in single ear	1.8
97. 60 decibels in single ear	2.3
98. 65 decibels in single ear	2.8
99. 70 decibels in single ear	3.4
100. 75 decibels in single ear	4.0
101. 80 decibels in single ear	5.0

Note: In bilateral deafness the poorer ear is rated according to the above scale; the better ear according to the scale multiplied by five. The sum of the two gives the combined rating.

102. Loss of one Kidney	10

Discussion of the Schedule including Proposed Amendments

Amputations in General

In assigning a rating level to any amputation it must be possible to assume that the stump is structurally perfect, that it is well padded, that the scar is properly placed and that there is no undue tenderness on areas which are subject to pressure. Irremediable defects may warrant a rating level above schedule. In the case of major limb amputations rating levels assigned have regard to the type and probable usefulness of the prosthesis to which they are adaptable.

Upper Limb Amputations

Major arm amputations have been re-classified into four rather than three categories. It is felt that amputation through the middle of the humerus deserves a somewhat higher rating than one in the lower third or with a more or less useless below elbow stump. Therefore, item #2 at 65% was added.

It was felt also that amputations between the biceps insertion and the wrist should be rated between 50% and 60% depending on the amount of leverage afforded by the length of the stump. For example, a 50% case would be represented by an amputation at the seat of election or at least not above the middle of the forearm. A 60% rating would be given if the stump is too short to afford any elbow control at all and a half way level where the leverage is only fair.

Finger Amputation

It will be noted that although amputations at the proximal interphalangeal joints of the four fingers remain unchanged, the distal phalanges have been given ratings equal to that of the second phalanges; viz. 3/10 of the value of the whole finger. This is because it is felt that the tactile function of the tips of the fingers has been insufficiently recognized. For a similar reason the distal phalanx of the thumb has been increased so that both phalanges rate equally though that of the whole thumb remains unchanged.

Immobility Of Joints (Upper Extremity)
In the case of immobility of any joint the assigned rating pre-supposes that the position of fixation is optimal, e.g. the elbow at approximately 90 deg. flexion, the distal joint of the thumb 40 deg. to 45 deg., etc. A finger capable of touching the tip of the thumb might be considered not more than 50% disabled.

Items 37,38 and 39 covering limited movement of the shoulder have been clarified providing a range of from 5% for simple fibrosis limiting abduction to 90 deg. without interfering with rotation to 35% for a completely "frozen shoulder".

Lower Limb Amputations
Short below-knee amputations unsuitable for a conventional B.K. prostheses and end bearing amputation at the knee have been given equal rating, viz. 45% and amputations through the foot are shown with a range of from 10% to 25% depending on the amputation level and the degree of ankle function. Amputation of any toe other than the great toe has been given a rating of .5%.

Immobility Of Joints (Lower Extremity)
The only change here is an increase of 5% i.e. from 20% to 25% for ankylosis of the knee. This increase was felt to be warranted to bring it into closer relationship to ankylosis of the hip.

Nerve Lesions
In the late schedule these cases, with the exception of peroneal paralysis (foot drop), were felt to be unsuitable for standard classification, however, in the hope they may be of some help as a guide, rating levels have also been assigned to complete lesions of the median and ulnar nerves.

Impairment Of Vision
No change is recommended for the present in any of the eye ratings despite the fact that some lack of uniformity still appears to exist with regard to some of the items, such as what constitutes an "industrially blind" eye and why aphakia should be rated lower than complete blindness. As to the former it should be recognized that retention of "form sense" of almost any degree is better than inability to see at all and there is plenty of evidence available that many workmen with no better than 20/200 vision in either eye carry on at work that does not require high visual acuity. Apart from the fact that a cataractous or aphakic eye that is otherwise normal is of great value to hold in reserve, the present excellence of contact lenses enables an individual with an aphakic eye to obtain relatively good binocular vision. With the exception of aphakia, eye ratings should be based on the best distant vision obtainable with conventional lenses.

Impairment Of Hearing
As it becomes better known that induced hearing loss is a compensable industrial disease in most Provinces more and more claims for this condition can be anticipated. While ability to hear and discriminate speech sounds is the most important function of the human ear, until it is possible to devise a uniformly satisfactory method of measuring speech reception it is recommended that we continue to follow the method of predicting the extent of hearing loss by having regard to the hearing threshold in the principle speech frequencies, viz. 500 cps., 1000 cps., and 2000 cps. as recommended by the Committee on the Evaluation of Hearing Defects of the A.M.A.

Nephrectomy And Splenectomy
Considerable discussion took place in committee as to the desirability of scheduling loss of a kidney or spleen. Some Boards allow 10%, others 15% for loss of either organ and there was one suggestion that nephrectomy should rate as high as 20%. In spite of the fact that loss of one kidney,providing the other is not in any sense a physical handicap, the consensus of opinion was that the reserve value of a second kidney would warrant an award of not more than 10%. Until proof is forthcoming that loss of the spleen constitutes a physical handicap, either real or potential, no award is suggested.

Applications of the Schedule

The Schedule Is A Guide
This or any schedule is at best only a guide, to be departed from if and when the occasion demands. It must always be regarded as a servant; never a master.

Cases of Special Hardship
While intended to apply to an average individual there will be cases where the rating level provides inadequate compensation to cover the economic hardship occasioned by an injury.

This happens mainly in the skilled trades where certain injuries impose particular hardship; for example, a plasterer unable to elevate his arm above shoulder level, or a railroad engineer who loses an eye. In such cases a special hardship allowance over and above the schedule rating must be considered.

Variable Factors
There are many factors that affect the rehabilitation prospects of handicapped people. Among these are age, nationality, mentality, education, physical and social environment, etc. With the exception of age these factors are difficult to evaluate. Men in the older age groups seldom become adept in the use of limb prostheses and no doubt some such cases should receive special consideration in the way of an increased rating of from ten to twenty percent for periods up to five years.

Timing Of Awards
Generally speaking awards may be made in amputation cases as soon as the workman is considered fit to work.

Joints immobilized by disuse should be given plenty of time to improve or return to normal. In severe injuries involving joints adjustments often have to be made later in the event of the development of arthropathy.

Corneal scars should be allowed plenty of time, often a year, to thin out before attempting to assess permanent visual impairment.

In cases of industrial noise deafness six months should be allowed to elapse after last exposure before assessing disability.

In certain cases of neurosis, hysteria, neurodermatitis and disinclination to bestir, early settlement often possesses therapeutic value.

Judgement Ratings
A sizeable proportion of all cases do not fall directly under the schedule in which cases the latter can only be used as a guide. Multiple finger amputations have been allotted values, but where there is scarring, impairment of joint movement and/or loss of sensation, the functional value remaining must be determined more or less arbitrarily and the percentage of disability so arrived at. Where several digits are impaired disability should be assessed in terms of the whole hand. In extensive injuries affecting several parts of the body the remaining functional faculty must be determined in terms of the whole man.

Digital Amputations
Removal of a phalangeal head adds nothing to the disability; indeed a better stump is usually thereby obtained. If more than the head is lost a good rule is to allow nothing for loss of less than half the phalanx, one third the value if half is lost and one half if two thirds are gone.

Amputation of metacarpal heads, except through surgical necessity, should be discouraged and for the most part allowed to go unrewarded, unless it is felt poor judgement on the surgeon's part would impose a hardship on the patient. Bevelling the heads of the second and fifth metacarpals for the purposes of streamlining the hand adds nothing to the disability, providing the procedure is carried out conservatively.

Disfigurement
Disfigurement deserves consideration only when treatment has nothing further to offer and when it is sufficiently serious to be a handicap in obtaining or holding employment. Ordinarily, facial, arm and even leg deformities, or scarring, are a greater handicap in women than in men and should receive added recognition.

Enhancement In Multiple Injuries
This is something to be considered where injuries involve parts of the body which perform identical functions; e.g. both arms, both legs or both eyes. Ordinarily there would be no enhancement factor as between a hand and a foot, a foot and an eye, etc. An enhancement of up to 50 percent might be warranted in injuries to both hands or both feet, but regard must always be had that the sum of the two individual ratings plus an added percentage for enhancement is not disproportionate when applied to the whole man.

Second Injury Funds

Most Boards have set up Second Injury Funds to take care of cases in which the disability resulting from an accident is greater by reason of some pre-existing injury or disease. The prime purpose of these funds is to help overcome employer reluctance to employ handicapped people, by spreading any added liability that might accrue thinly over all of industry. The actual cost of any enhancement is charged directly to the fund.

Mechanics of Rating in Special Cases

Multiple Finger Amputations

The computation of awards in multiple finger amputations often presents a problem. The schedule gives values for complete loss of two or more fingers, but where unequal parts of fingers are involved, a method of calculating the disability becomes necessary.

A formula is presented by the use of which a quick and convenient means of reaching the objective is afforded. It is based on the premise that while each individual finger has a fixed value, when two or more fingers are lost, an enhancement factor has to be considered over and above the sum of the individual losses. For example, if the index and middle fingers each have a value of 4%, but a combined value of 14%, it follows that the enhancement factor if both are lost is 6% — i.e., 4% + 4% + 6% × 14%. If, for example, the index finger is off at its proximal joint and the middle at the p.i.p. joint, the combined disability would be 4% + 3/5 × 10% × 10%.

At first sight the formula may seem complicated, but after a little trial and experimentation, little difficulty should be experienced in working out the rating in any combination of finger amputations. Simply remember to use the four finger chart if four fingers are involved, the three finger chart if three fingers are involved, etc. Having done so, check off the distal-most components of the four fingers or three fingers as the case may be, then turn to the lesser finger combination and do likewise. Finally add all together. The values of all components conform with the finger ratings in the schedule.

Impairment Of Vision

In rating visual impairment the percentage of disability should be based on the best vision obtainable after correction with conventional lenses, using the standard Snellen test card at a distance of twenty feet with minimum illumination of five foot candles. The only exception is in monocular aphakia where even if fully correctable the eye lacks the power of accommodation and the image is different in size from that in the normal eye. In the case of bilateral aphakia on the other hand providing both eyes are otherwise normal, bi-focal lenses will give good visual acuity of both near and distance. For such cases a 20% rating is suggested.

In the case of bilateral visual impairment each eye should be rated separately and to the rating applicable to the poorer eye should be added 84/16 times the rating applicable to the better eye to arrive at the combined percentage of disability.

In cases of diplopia in all fields the rating is slightly less than in monocular aphakia because the eye, assuming it is otherwise normal, retains the power to accommodate for distance and hence is a valuable eye to hold in reserve. Diplopia is often present in only part of the field or even only in one quadrant. These cases, providing the visual axes are unaffected, are of comparatively minor importance and often right themselves or are correctable with prisms. Diplopia below the horizontal is a greater handicap that one above.

There are several varieties of field defects. The most striking is homogeneous hemianopia which produces blindness in half the visual field of both eyes, the nasal half of one eye and the temporal half of the other. Usually the fixation points are not involved. A right field hemianopia would merit a rating of 25% compared with 20% for one involving the left fields as it is a greater handicap in reading or driving a car.

The importance of limited field defects (scotomata) depends on their size and location. A central scotoma (in the line of direct vision) might warrant a rating of 75% loss of vision. Defects elsewhere in the visual field unless quite large are of relatively minor importance.

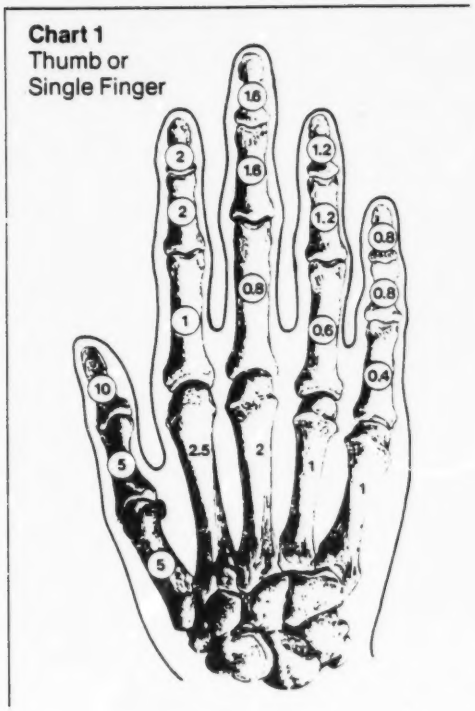

CHART 1 —
THUMB OR
SINGLE FINGER

AWARD HALF VALUE SHOWN IF DISABILITY ONLY INVOLVES A SINGLE PHALANX.

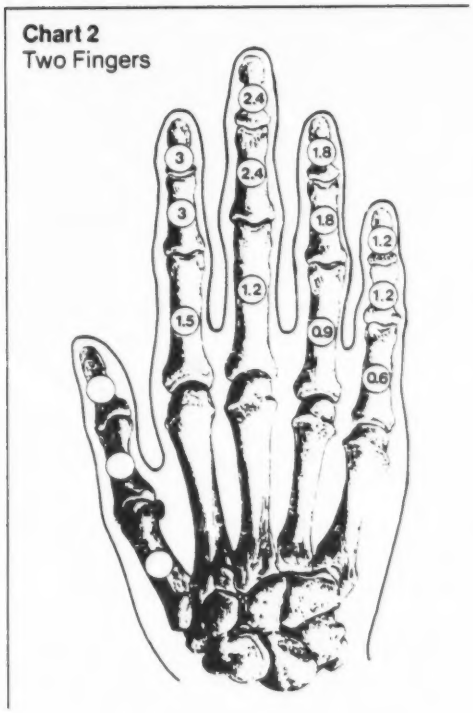

CHART 2 - 2 FINGERS

1½ Times The Sum Of The Single Values

Index & Middle at distal	5.4
Index & Ring at distal	4.8
Index & Little at distal	4.2
Middle & Ring at distal	4.2
Middle & Little at distal	3.6
Ring & Little at distal	3.
Index & Middle at P.I.P.	10.8
Index & Ring at P.I.P.	9.6
Index & Little at P.I.P.	8.4
Middle & Ring at P.I.P.	8.4
Middle & Little at P.I.P.	7.2
Ring & Little at P.I.P.	6.
Index & Middle at Metacarpal	13.5
Index & Ring at Metacarpal	12.
Index & Little at Metacarpal	10.5
Middle & Rink at Metacarpal	10.5
Middle & Little at Metacarpal	9.
Ring & Little at Metacarpal	7.5

Chart 3
Three Fingers

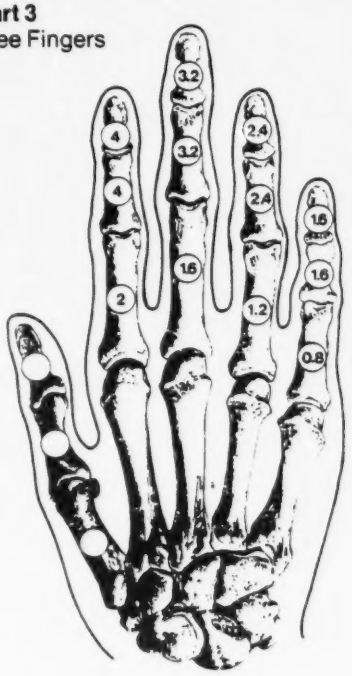

CHART 3 - 3 FINGERS

Twice The Sum Of The Single Values

Index & Middle with Ring at distal	9.6
Index & Middle with Little at distal	8.8
Index & Ring with Little at distal	8.
Middle & Ring with Little at distal	7.2
Index & Middle with Ring at P.I.P.	19.
Index & Middle with Little at P.I.P.	17.6
Index & Ring with Little at P.I.P.	16.
Middle & Ring with Little at P.I.P.	14.4
Index & Middle with Ring at Metacarpal	24.
Index & Middle with Little at Metacarpal	22.
Index & Ring with Little at Metacarpal	20.
Middle & Ring with Little at Metacarpal	18.

Chart 4
Four Fingers

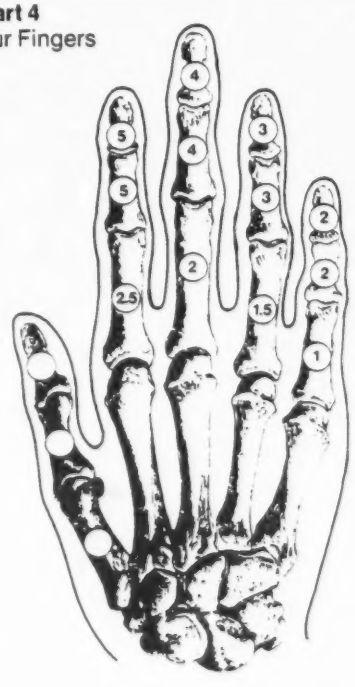

CHART 4-4 FINGERS

2½ Times The Sum Of The Single Values

Index, Middle, Ring & Little at distal	14.
Index, Middle, Ring & Little at P.I.P.	28.
Index, Middle, Ring & Little at Metacarpal	35.

Occupational Hearing Loss

(1) **Traumatic:** sudden deafness, one or both ears affected by e.g. blast or head injury.

The deafness may be of varying degrees, with or without tinnitus. In some cases surgery may improve the hearing.

	Percentage
Deafness, complete in one ear	5
Deafness, complete in both ears	30
Sudden and traumatic complete deafness	60
Hearing Loss — one ear only	
over 30 dB A.N.S.I.	1
over 40 dB	2
over 50 dB	3
over 60 dB	4
over 70 dB	5
Traumatic Vertigo	2.5
Tinnitus	up to 5

(2) **Noise induced:** gradual onset, both ears affected

To establish a claim, all the following circumstances must apply:

1. There is a clear and adequate history of five or more years of exposure to hazardous noise, 85 decibels 'A' scale, for eight hours per day, or equivalent as noted below:

Sound Level (dB)	Duration Hours/24
80	16
85	8
90	4
95	2
100	1
105	0.5
110	0.25
115*	0.125

*No exposure to steady-state noise in excess of 115 dBA is permitted

Permissible Noise Exposure (Impulse or Impact Noise)

Permitted Number of Impulses or Impacts per 24 Hours	Sound Level (dB)
0	Above 140*
100	140
1,000	130
10,000	120

*No exposure to impulse or impact noise in excess of 140 decibels peak sound pressure level is permitted

Note: Sound levels in excess of 85 decibels ('A' Scale) will reduce the five or more year exposure requirement.

2. The frequency level and type of exposure is known.

3. The average of the four speech frequency levels 500, 1000, 2000 and 3000 Hertz (Hz) in the American National Standards Institute (ANSI) or International Standards Organization (ISO) audiograms is 25 decibels in each ear.

   Since individual susceptibility to noise varies, cases which do not meet the criteria set out above are individually judged on their own merits having regard to the nature of the occupation, the extent of exposure and any other factors peculiar to the individual case.

To Establish Entitlement to Permanent Impairment all of the Following Circumstances must apply:

(a) The average of the four speech frequency levels, 500, 1000, 2000 and 3000 Hz in the ANSI or ISO audiograms is 35 decibels in each ear.

(b) A presbycusis factor of .5 dB for each year that the age exceeds sixty is deducted;

(c) Hearing Loss is decibels is converted into percentage of impairment in accordance with the following schedule:

Hearing Loss Where Both Ears Are Affected:

dB Hearing Loss	**Percentage**
In single ear 35 dB ANSI/ISO	.4
In single ear 40 dB ANSI/ISO	.7
In single ear 45 dB ANSI/ISO	1.0
In single ear 50 dB ANSI/ISO	1.4
In single ear 55 dB ANSI/ISO	1.8
In single ear 60 dB ANSI/ISO	2.3
In single ear 65 dB ANSI/ISO	2.8
In single ear 70 dB ANSI/ISO	3.4
In single ear 75 dB ANSI/ISO	4.0
In single ear 80 dB ANSI/ISO	5.0

Note: In bilateral deafness the poorer ear is rated according to the above scale, the better ear according to the scale multiplied by five. The sum of the two gives the combined rating.

(d) The level of rating is not influenced by any improvement in hearing attained through the use of a hearing aid.

(3) Industrial Noise Induced Tinnitus

To establish entitlement for permanent impairment for tinnitus, *all* of the following circumstances must apply:

1. There is an acceptable claim for industrial noise-induced hearing loss.

2. There is a clear and adequate history of two or more years of bilateral continuous and severe tinnitus.

3. The condition has been confirmed by a consultant with facilities for testing peculiar to tinnitus.

4. Claims which do not meet the above criteria are individually judged on their own merit.

5. Permanent impairment rating for tinnitus shall not exceed two percent, except under unusual circumstances (maximum 5%).